THREE RIVERS
PUBLIC HEALTH DEPARTMENT
Dodge, Saunders & Washington Counties

Office Use:
Lot #: _____
Site: _____
Nurse: _____

Adult Immunization Information

Last Name: _____ First Name: _____ Middle Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Gender: □ Female □ Male Phone Number: _____

Date of Birth: _____ Country of Birth: _____ County of Residence: _____

Ethnicity: □White □ Black or African American □ Native Hawaiian or Pacific Islander
□ Asian □ Alaska Native □ Hispanic or Latino

INSURANCE
□ No Insurance

□ Medicare Number: _____ □ Part A □ Part B

□Insurance Company:_____ Insurance Mailing Address:_____
Policy holders name :_____ Your Relationship to Insured: □Self □Spouse □Child
Policy holders Birthday___/___/____Insured ID #:_____ Group #:_____

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	No	Yes
1. Are you sick today?	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
Have you had a mammogram in the last 2 years?	☐	☐
Have you had a pap test in the last 3 years?	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐

IF APPLICABLE: I hereby authorize my insurance benefits to be paid directly to the clinic and acknowledge that I am financially responsible for any unpaid balance. I also authorize the clinic to release any information requested by my insurance company.

Signature of vaccination consent:_____ **Date:** _____